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ABSTRACT

The paper addresses issues in counseling the retarded in the context of the research literature, identifies promising trends, and proposes a counseling model. Three issues are identified: the necessity for counseling to meet measurable objectives; the need for cost effectiveness; and the need for an integrated model. After proposing a definition of counseling which focuses on behavior change, the literature is summarized on use of the psychodynamic, behavior therapy, nondirective, and directive group counseling approaches with the retarded. The research as a whole is characterized as having poor research design which renders most of the conclusions as to counseling effectiveness invalid. Current trends in treatment include social skills training, the use of social skills counseling models, self-management training, and emotional training. There is an increase in clinicians who use eclectic approaches, often associated with inadequate planning, idiosyncratic interventions, and procedures of unknown benefit. Characteristics of a useful counseling model include: (1) internal validity; (2) specific consideration of the learning characteristics of the retarded individual; (3) use of techniques validated by the experimental and applied literature; (4) use of techniques that can address concerns in behavioral, cognitive and affective areas; and (5) cost effectiveness. (DB)

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Counseling Approaches with Retarded Persons: Current Status and an Attempt at Integration

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Paper presented at the Region IV Conference of the American Association on Mental Deficiency, Snowmass, Colorado, October 1983.

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Counseling Approaches with Retarded Persons: Current Status and an Attempt at Integration

Some of you in the audience may be wondering if it may not be somewhat premature to include a discussion of counseling techniques with the retarded under a program theme of "Techniques that Work," and based on the available data I confess to some misgivings myself. The objective observor might well conclude that counseling approaches as presently practiced with this population have fallen far short of demonstrating effectiveness, and my purpose is not to attempt to persuade you otherwise. Nevertheless, we should make a distinction between effectiveness and evaluation. Frequently, techniques and practices of genuine benefit suffer from the stigma of ineffectiveness because they are either evaluated in an unsophisticated manner or the relevent functional processes are not easily isolated, identified or objectively examined. Therefore, while I will not be asking anyone here this afternoon to take anything on faith, I do hope that you might leave with an increased awareness of the issues involved and how we might attempt to resolve them. In the meantime, you might simply regard me as something of a devil's advocate on the general subject.

I would like to begin today's discussion with an observation, which is that research activity in the area of counseling the retarded has leveled off in recent years, and may in fact be declining, despite the fact that little seems to have been settled. This does not appear to be the result of consistently negative findings (there is no end to enthusiastic testimony that counseling the retarded is beneficial) although it is true that what research

there is has generally been very sloppy. It is also true that recent advances in behavioral psychology seem to have people a good deal more excited than the counseling field vis a vis the mentally retarded.

What is curious is the timing of this apparent decline of interest. At the present time, we are faced with an unprecedented demand for mental health services for the mentally retarded, a population in which the incidence of emotional-behavioral disorders is comparatively high, while shortages of trained mental health providers persist. As more and more developmentally disabled individuals are relocated from institutions and as the normalization principle results in greater individual freedoms for the mentally retarded (including the right to treatment with the least restrictive modality), we are beginning to belatedly discover that techniques that have served us well in controlled environments have some significant limitations in the "real world." In the meantime, we are making a considerable number of demands on people we would like to see normalized but who are not, because we have not given sufficient attention to the emotional demands of society and the repetoire of skills necessary to cope with them.

Why, then, is there less interest in counseling as a medium of behavior change (as reflected by the literature) than in prior years? There are at least three reasons.

First, the current climate of accountability dictates that psychological interventions, like any others, must be able to meet measureable objectives. While in principle this seems a reasonable goal, it is by no means an easy one for clinicians who have traditionally emphasized global, complex, and elusive personality constructs and who lack the necessary measurement tools to ob-

jectively evaluate their work with the mentally retarded.

A second issue is that of cost effectiveness. Clients seen individually or in small groups by expensive clinicians for long periods of time with unpredictable and largely unmeasureable results is simply not an efficient way of managing one's resources, particularly in an era of funding cutbacks.

It may be that the problems of accountability and cost effectiveness may ultimately be manageable, given the technological resources available. But we must also address a third issue, one which I believe to be the major reason why counseling the retarded is not being more aggressively pursued.

To anyone who has spent time trying to make sense of the available literature on counseling the mentally retarded, it should be manifestly evident that the field suffers from a lack of direction. Normally, an approach to a problem as potentially complex as counseling must be taken in a painstaking and logical fashion. Various elements of the problem are critically examined in isolation before they are combined with others and evolve into a therapeutic package. To a large extent, this has not occurred with counseling the retarded. Those studies which have alleged success in counseling with the retarded can, for the most part, just barely demonstrate that change has occurred, let alone how or why. Most do not generate testable hypotheses to account for the change process or to guide future research in the area. Techniques and procedures used vary so widely from study to study that comparisons are impossible to make. Few authors have attempted to expand upon or replicate their own work, or that of others. There has been a perilous disregard for the results of previous investgations and for research in related areas. Not only do we not

know where we are going, I doubt seriously that we know where we have been!

My purpose this afternoon is multifaceted. I would like to address these and other issues beginning with a brief evaluative summary of the available literature, then try to identify some promising trends and obstacles to overcome, and finally to close with some suggestions for integration and a brief discussion of what I consider to be characteristics of a useful counseling model for the mentally retarded.

First, however, we need a definition of the counseling process. There are, of course, as many definitions of counseling as there are therapists, but most seem disturbingly limiting. That this, they are based on assumptions that seem applicable only to the more traditional, verbal, and insight-oriented psychotherapies. Traditional notions of therapy are, after all, based on approaches designed for persons with average or better intelligence who nevertheless seem willing to invest a good portion of their average or better incomes on procedures of questionable value and benefit. At any rate, I prefer the following definition because first, it offers a considerable degree of flexibility, and second, it is in keeping with the general trend toward operationalism. Counseling is viewed as:

> any planned or "goal directed" attempt to create behavioral change in the patient, regardless of the materials or procedures used -- as long as an effort has been made to establish a close interpersonal relationship between the patient and the therapist, as long as an effort has been made to create an organized treatment setting, and as long as the processes of communication are emphasized. (Leland & Smith, 1965, p. 57)

Such a descriptive, quasi-operational definition of counseling does not assume a priori any particular cognitive requisites for counseling, nor does

it attempt to predict any non-observable outcomes. It does, however, implicitly recognize that procedures may be developed for special populations that depart radically from traditional counseling practices. Note further that it is the process of behavior change that is emphasized, leading one to conclude that behavioral outcomes are those which determine levels of emotional adjustment.

I would like to take a look now at some of the major schools of psychological treatment/counseling and the results of applications of these techniques with the mentally retarded. The studies on which this critique is based include at least a majority of subjects who appear to meet the AAMD/DSM-III criteria for mental retardation.[1]

Psychodynamic Approaches

Although psychodynamic therapies are no longer monolithic in approach, most still emphasize conflict and anxiety as being at the root of most psychological disturbances,the basis of which are factors not immediately accessible to consciousness (Wachtel, 1982). Treatment of the mentally retarded individual is characterized by simple interpretations of verbal material, analyses of fantasies (as opposed to dreams), symbolic behaviors, and defense mechanisms; and some work with interpretation and analysis of transference and countertransference. Techniques that require a more sophisticated level of verbal behavior such as free association and the recounting of dream material are less emphasized and are generally considered of limited value (Fine, 1965).

[1]The studies and conclusions included in this paper not otherwise accompanied by supporting citations are based on my recent (Spragg, Note 1) review of the literature.

As with non-retarded persons, treatment is usually a long-term process. Published accounts with the retarded generally focus on individual therapy, although there are a few reports of group dynamic treatment as well. Most of these investigations have been descriptive in nature, reflecting a traditional dynamic emphasis on process questions as opposed to behavioral outcomes.

As we have already noted, however, it is becoming increasingly difficult to justify the use of techniques which are not specifically goal-directed and which therefore do not lend themselves well to objective evaluation. Consider the following statement, abstracted from an exceptionally detailed analysis of a mentally retarded patient in long-term psychotherapy for episodic tantrums and aggressive behaviors: "At the end of two years, [the patient] told me that he did not wish to come any more. I do not know whether the treatment was a success or failure." (Symington, 1981, p. 187) Statements such as this, while agonizingly honest, certainly seem to stretch the bounds of credibility if their purpose is to provide support for the beneficial effects of psychodynamic treatment, as the author later implies. Clinicians can no longer expect to be well received by increasingly skeptical administrators, consumer-oriented staff, advocates, and caretakers if progress in treatment is evaluated on the basis of subjective impressions lacking in external validity.

Behavior Therapy

While the major part of the literature applying behavior change methodologies to the mentally retarded concerns itself with operant reinforcement modes of intervention, the respondent therapies have been investigated as well. Early attempts at "behavioral counseling" with the retarded, however, attempted to

establish a relationship between the modification of verbal responses in the counseling setting and subsequent behavior in other environments (Doubros, 1966). Such approaches yielded controversial results and were roundly criticized on both methodological and theoretical grounds (Brodsky, 1967; Gardner & Stamm, 1971).

Greater success has been obtained with applications of classical conditioning (respondent) learning techniques, clinically most familiar as the counter conditioning therapies such as systematic desensitization. Systematic desensitization is widely used to counteract phobic responses and other anxiety-based neurotic disorders.

It has been pointed out that mentally retarded persons generally experience more contingent aversive consequences than non-retarded individuals, and consequently their behavior is characterized by a great deal of avoidance behavior (Bijou, 1966). It has been recently noted that the mentally retarded individual may be especially susceptible to fears that accompany community placement (Matson, 1981). Desensitization may therefore be considered a logical means of reducing feared consequences to pave the way for more adaptive learning. The potential advantage of this technique with the mentally retarded is that there is minimal reliance on symbolic communication, insight, and complex interpersonal dynamics.

Because of a reduced capacity for most mentally retarded individuals to conjure up appropriate imagery (necessary for imaginal procedures), most studies have employed in-vivo or contact desensitization procedures. In addition, some form of social or tangible reinforcer is used as the counter-

conditioning agent, despite mounting evidence that the mentally retarded are capable of learning the relaxation response (Wolfzahn, 1980).

There are several case reports detailing the successful use of desensitization procedures for various monophobic conditions in the mentally retarded. Viewed collectively, these investigations suggest that mentally retarded adults and children are capable of performing critical desensitization tasks. However, additional research is necessary to clarify the effects of variables external to treatment, including the effects of therapist attention, client expectancies, and the social demand characteristics of the therapeutic setting. In addition, future research needs to examine the role of purely operant mechanisms in treatment (e.g., behavior shaping via reinforcement of successive approximations), particularly if it is not clear whether the phobic behavior is truly anxiety-based (classically conditioned) or in fact represents a positively or negatively reinforced avoidance response.

Nondirective (Group-Centered) Approaches

A variety of studies have attempted to apply the techniques of client-centered (nondirective) therapy (Rogers, 1951) to the mentally retarded. In this school of counseling, emphasis is placed on the relationship between the client and therapist as the primary catalyst of change. Critical therapist attitudes believed to facilitate therapeutic movement include unconditional positive regard, empathic understanding, and genuineness (Corey, 1977).

Results of the studies I have been able to locate that utilize this mode of treatment seem to support earlier opinions that non-directive approaches have only limited applicability to the mentally retarded (Rogers, 1951; Sternlicht, 1963; Vail, 1955). The one study that reported positive findings

(Etchegoinberry, 1975) included a majority of subjects of questionable retardation (EMR students) and utilized a highly questionable statistical procedure in arriving at the results (multiple t-tests) that did not rule out chance factors to an acceptable level of confidence.

The limitations of non-directive treatment may be due not only to the assumptions underlying the approach (e.g., requisite skills of clients) but also because it appears to be a common finding that in group sessions, chaos rapidly ensues unless structure is imposed by the therapist. One investigator (Fine, 1969) was even compelled to abort his investigation prematurely at the request of school officials when his group became too unruly.

What little there is in the way of the counseling process literature tends to shed some light on this problem. It appears that an excessive amount of time is required to develope the counselor-client relationship, and that the essential character of communication in therapy tends to be information-seeking on the part of the therapist and information-giving on the part of the client. (Rose, 1971). Non-problem focused material shows an increase over time (Stone & Coughlan, 1973). In response to counselor probes, mentally retarded clients are typically found not to be discussing meaningful personal material but are instead conducting the conversation on a superficial level (Garfield, 1971). In other words, in response to a nondirective approach, mentally retarded individuals typically stray from the task at hand and show little inclination for personal exploration without the imposition of structure and active leadership by the therapist, particularly in group settings.

Directive Groups

For these reasons, most investigators have advocated the use of directive

treatment strategies. There exists a large body of research that has largely confirmed the relative superiority of directive techniques with the mentally retarded over nondirective approaches, primarily because the client's attention to task is more easily focused, there is less emphasis on insightful learning, and specific behavioral alternatives can be discussed and practiced. Therapists utilizing directive treatment strategies fall into two main camps: those who have experimented with applications or modifications of traditional approaches, and those adopting a more eclectic view.

Traditional Approaches

Applications of traditional treatment approaches have included such diverse strategies as reality therapy, existential therapy, transactional analysis, and psychodrama and sociodrama. None of these investigations have yielded statistically compelling results, although modest treatment effects are sometimes reported.

Non-specific Group Approaches

In contrast to the familiar approaches cited above, there are numerous descriptive (i.e., non-experimental design) accounts of eclectic group treatment for the mentally retarded adult. Between 15 and 20 published studies have concluded that directive group treatment is effective and beneficial for the mentally retarded. Many of these studies focus on preparing clients for adjustment to placement in community settings. Therapy goals have typically included the development of social and personal skills, instilling a sense of personal responsibility, increasing personal independence and improving self-concept in a variety of mentally retarded populations.

While some early investigators advocated a highly structured, didactic

approach to treatment, in recent years more emphasis has been given to the creation of the therapeutic environment. For the most part, the therapist is considered a facilitator of the group as opposed to a teacher. Typically, group members are encouraged to set the agenda for the session by sharing a need, concern, or conflict which is then reacted to by the other group members.

The role of the group facilitator, or leader, is typically an active one and he or she assumes certain responsibilities in terms of structuring or directing the group process. First, the group leader will attempt, by his or her own behaviors, to establish a warm and accepting environment in order to facilitate free discussion and the open exploration of feelings and concerns by the individual group members.

Secondly, it is often the role of the therapist to maintain order, set limits, and to keep the group on-task and goal-directed in order to prevent it from floundering. This is accomplished by introducing group rules early on, and by occasionally intervening and re-directing the exchanges of members.

Finally, the therapist also serves to clarify and reflect the thoughts and feelings expressed by group members, provides needed information, materials, or activities, assists in the structuring of problem-solving discussions, and models and reinforces appropriate group behaviors such as listening and providing constructive feedback. Although group treatment is characterized primarily by discussion and information-sharing, it appears to be advantageous to include a variety of crafts, activities, excursions to the community, role-play and other social learning exercises, etc.

Authors of descriptive accounts often evaluate therapeutic outcome in terms of clinical impressions and subjective, post hoc data concerning post-treatment adjustment. This is one reason that, while consensual findings such as these are certainly of interest, their value is somewhat limited because they are so difficult to evaluate objectively.

The fact that the descriptive literature lacks experimental objectivity is not necessarily a reason to dismiss it out of hand. Yet, the fact of the matter is that when studies are conducted within the context of true experimental designs, the results of directive treatment are far more equivocal.

Most of the better designed studies focus on the effects of group counseling with mentally retarded school children and adolescents. A review of this work suggests that, under certain conditions, directive group therapy can lead to measureable improvement in self-concept, anxiety, behavior, academic performance, and personality adjustment.

It should be noted, however, that these are by no means consistent or even typical findings. There are instances in which studies evaluating comparable treatment programs and utilizing the same or similar dependent measures yield conflicting results. Other studies are frankly suspect. For example, of the studies I have found, at least half reported treatment durations of 14 weeks or less. From a purely theoretical standpoint, significant changes in personality functioning and self-attitudes occurring in persons of limited intellect, with life-long histories of emotional, social, and environmental deprivation, as a result of brief treatment appears implausible. It may be the case that the dependent measures themselves are highly reactive

when used with the mentally retarded client, or are less valid and reliable with this population, which can result in spurious outcomes. Such results may also be the result of chance variability, and it is well to bear in mind that studies resulting in negative outcomes only rarely find their way into the literature. I do think it is telling that not one of these authors has published a replication of their findings.

Methodological Critique

The single biggest problem that can be laid at the door of these studies, however, is simply poor research design. For those of you with an affinity for these kinds of things, the array of methodological problems is staggering. Examples include erroneously classified subjects, absent or inadequate control groups, uncontrolled rater bias, misapplied statistical analyses, irrelevent or inappropriate dependent measures, and lack of generalization and follow-up data. To give you an idea of the extent of the problem, of those studies reviewed that reported statistically meaningful improvement on at least one objective measure (about half), every one contained at least one of these flaws, any one of which renders the results of a study, if not completely invalid, then at least extremely suspect.

Of those studies not detecting any changes as a result of treatment, most of the authors cite the insensitivity of their instruments as a main reason why their data did not conform to their clinical impressions. While there is little question that greater attention needs to be given to the problem of outcome measurement, the possibility that treatment is simply not effective is often somehow overlooked.

This sorry state of affairs is not helped by the lack of information on

the subjects themselves (which could be of enormous help to other investigators) or the extreme variability of subjects, procedures, and design from study to study. These problems make comparisons of studies extremely difficult. In some cases, the nature of the treatment employed is not adequately described and therefore its efficacy is not verifiable by replication. There is also an apalling disregard of the findings of previous investigators, as well as a failure to integrate research from allied fields such as learning, development, motivation and personality in mental retardation. Only in the field of counselling, as far as I can tell, is active research being conducted without an adequate theoretical base. What has evolved instead is a patchwork of approaches, with none attempting to present a unified system of theory and practice, that do not generate testable hypotheses, and consequently contribute little to our understanding of the therapeutic process.

This indictment of research methodology should not be construed as condemming the potential value of the techniques themselves. What is evident, though and requires recognition is that the better designed studies typically result in fewer significantly positive reported outcomes. What is not yet clear is whether negative outcomes reflect the ineffectiveness of counseling procedures with the mentally retarded or the failure to adequately address certain crucial treatment and methodological variables.

I submit that fresh start and perspective on the problem is required. To that end, I will devote the remainder of this presentation to an examination of what I consider to be some of the more important issues in counseling the retarded, and attempt to identify some important trends that have implications for both theory and treatment of the retarded individual.

Current Trends in Treatment

I will start with a brief overview of what is happening today in the general area of psychological intervention with the mentally retarded. There are at least four bodies of research or trends of interest that I wish to call to your attention.

Social Skills Training

The first of these is social skills training procedures. Social skills have been defined as "the complex ability to maximize the rate of positive reinforcement and to minimize the strength of punishment from others." (Libet & Lewinsohn, 1973, p. 311) The absence of appropriate social skills in the mentally retarded is considered to be a main cause for failures in community placements (Stacy, Doleys, & Malcolm, 1979). As such, their development represents a high priority for counseling and related interventions.

Social skills training, which is based on observational learning principles, is a method of increasing an individual's ability to perform competently in critical social situations. Treatment is formalized and multifaceted, generally consisting of a "package" of techniques that includes verbal instructions, modeling of appropriate behaviors, role-play and behavioral rehearsal, response feedback, reinforcement, and occasionally, homework assignments. This procedure, which is characterized by a virtual explosion of research in the last five years, has had good success in training verbal and non-verbal communication skills, cooperative behaviors, the appropriate expression of anger, assertive skills,

and in the remediation of the behavioral characteristics of depression.

Social skills training is not without limitations, however, and foremost among them is the focus on a relatively narrow range of discrete behaviors. Secondly, many studies are lacking in follow-up data and those that include it often find a response decrement on re-testing.Although generalization can be obtained when training occurs in the natural environment (Matson & Earnhart, 1981), studies also show only a modest relationship between proficiency at role-playing and behavior in naturalistic settings (e.g., McNamara & Blumer, 1982).

Social Skills Counseling Models

One interesting development has been the emergence of social skills counseling packages that incorporate social skills training procedures into their curricula. Such models are characterized by common features: (1) a highly structured social competence curriculum addressing a variety of skills such as assertiveness, appropriate social and sexual behavior, personal appearance and mannerisms, awareness of feelings, and "making friends;" (2) an underlying emphasis on counselor variables that promote therapeutic movement; (3) social skills training techniques and directed group strategies; and (4), time limited treatment.

Social skills counseling differs from procedural social skills training in that while the latter generally targets only a narrow range of discrete behaviors, social skills counseling places more emphasis on broad characteristics of interpersonal functioning. Consequently, social skills counseling tends to be of somewhat longer duration. Secondly,

social skills counseling is conducted within a group setting, which is not typical of studies on social skills training. Third, counselor/therapist variables are not given as much emphasis in social skills training, which is primarily a didactic approach to treatment. Finally, measures of social skills counseling models tend to be global rather than discrete, consistent with its more general treatment goals.

What is significant about social skills counseling is that it represents the first attempt to design a counseling approach specifically for the mentally retarded. Examples include Personal Adjustment Training (Zisfein & Rosen, 1973) -- the results of which have been largely disappointing -- and Social Adjustment Training (Lee, 1977). While the results of SAT have been more encouraging, the author himself notes a number of potentially serious limitations in the methodology of his study.

A more general criticism of the work in social skills counseling is that these studies have provided little evidence that emphasis on more traditional counseling variables adds measureably to treatment effects. Indeed, if anything one must entertain the possibility that the reverse is true. In addition, one has to wonder about the permanence of treatment effects in institutional settings (where these studies occurred) where targeted behaviors are not likely to be reinforced by naturally available consequences.

Nevertheless, the conceptual advancement that these models represent should be stressed, as they represent the first attempts to formally integrate behavioral methodology into a more traditional counseling frame-

work. In a way, they may be regarded as having emerged somewhat prematurely, predating as they did the bulk of the more methodologically sophisticated literature in social skills training and outcome measurement with the mentally retarded. Such models illustrate the dangers of making quantum leaps in practice before the component elements of treatment have been fully established and validated. It is tempting to speculate whether revisions in these models, based on the current literature, might result in more favorable outcomes.

Self-Management

A third area of interest is that of self-management. Mentally retarded individuals are frequently characterized as being unable to control their own behavior, as being excessively dependent, and as outer-directed in their problem-solving orientation (Litrownik, Freitas, & Franzini, 1978). With the current emphasis on deinstitutionalization and community placement, techniques that develope greater self-reliance and self-directedness have important implications for transfer and generalization of clinical treatment. Self-management (also termed self-regulation or self-control) refers to the process of managing one's own behavior through the self-regulation of operant or coverant cues and consequences (Kurtz & Neisworth, 1976). There has been a growing interest in the potential applications of self-management with the mentally retarded.

There is preliminary evidence that, under experimental conditions, both mentally retarded children and adults are capable of learning the component elements of self-management examined separately including

standard setting, self-monitoring, self-evaluation, and self-reinforcement. They have also been combined in various self-management packages to successfully reduce instances of socially disruptive behaviors in the mentally retarded. This is an area that has considerable promise with the mentally retarded and there is every reason to suspect that it will continue to generate important clinical applications in the years to come.

Emotional Training

There is, lastly, a final area of interest that is only now beginning to receive attention in the experimental literature. The area concerns affect and its relationship to emotional development, personality, behavior, psychopathology, and treatment. Several authors have suggested recently that affect be assigned a more central role in the regulation of psychological functioning (Rachman, 1981; Zajonc, 1980), and even some behavioral psychologists anticipate that it will become an increased focus of behavior therapy (Wilson, 1982).

The relationship between affect and behavior change has not yet been well delineated, but several intriguing lines of inquiry are being examined. For example, it has been argued by some that individuals who are indifferent or insensitive to negative emotion communications or who are unable to appreciate their significance (i.e., who demonstrate impaired emotional discrimination and evaluation) might also be expected to violate the guidelines that typically define acceptable behavior (Savitsky & Eby, 1979). The mentally retarded appear to be particularly vulnerable to

emotion discrimination deficits, and there is preliminary data suggesting a relationship between these deficits and social judgement (Spragg, 1983).

Using an affect training package developed here in Colorado by Bell and his colleagues (Bell, Corcoran, Delaney, Kirchner, & Levinson, 1976), we have been able to demonstrate significant improvement in emotion identification and discrimination in a group of moderately retarded individuals after 20 weeks of training (Spragg, 1983). While behavior changes as a result of such training have yet to be convincingly demonstrated, the fact that relatively low functioning, mentally retarded individuals are able to increase their awareness of emotions suggests that it is possible to train increased attending to subtle interpersonal cues that may in turn dictate one's own response to another.

Treatment Selection and Eclecticism

The foregoing review suggests that a wide variety of techniques and approaches have current or potential applications in counseling the mentally retarded. However, any attempt to produce behavior changes in a retarded individual, irrespective of treatment philosophy, must address at least three questions: (1) What are we trying to accomplish? (2) What is the best way to get there? and (3) How do we know when we have arrived? The first and last questions address the problems of goal selection and outcome measurement, respectively, and although important are beyond the scope of today's presentation.

The process of treatment selection, however, is something that I wish to touch on as a matter of particular concern, as it is seldom given much

more than perfunctory treatment by the authors of the outcome studies I have reviewed. At times, the choice of strategies seems to be made quite arbitrarily, without adequate consideration given to the individual strengths and needs of the client. More often than not, treatment with the retarded appears to be a trial and error process, the therapist appearing to lack a clear idea of direction and apparently sort of "making things up" as s/he goes along. Clearly, the selection and rationale for the choice of treatment strategies, being a multifaceted process, as well as the most important early decision the therapist will make, should receive more emphasis.

In the mainstream of clinical practice, there exists an increasing percentage of clinicians identifying themselves as "eclectic" (Garfield, 1982). I suspect that this is particularly true of those working with the retarded client. There are, of course, obvious advantages of drawing on the "best" of what the various models have to offer, not the least of which is that adhering too rigidly to any school of therapy may mean that certain variables and relationships are overlooked because a given theory does not emphasize them.

Eclectic practice with the mentally retarded, however, presents special problems and limitations. Whereas eclectic therapists treating non-disabled populations can generally draw upon both theoretical and empirical rationales in justifying any given combination of procedures, treatment of the retarded is based largely on the therapist's own experience. The reasons are not difficult to appreciate.

First, we must emphasize again that at the present time, the field of counseling the retarded lacks an adequate theoretical basis in a number of important respects, especially with regard to personality development and psychopathology in the developmentally atypical. In the absence of such framework there is a tendency to muddle about until one stumbles on something that seems to work. The danger here is that some aspects of the mentally retarded client's emotional/behavioral functioning requiring attention are easily disregarded. Paradoxically, while the practice of eclectic treatment theoretically minimizes this possibility, it may result in just the reverse with the retarded client.

Secondly, the role of differential diagnosis has extremely important implications with the retarded client. Accurate differential diagnosis permits the therapist to draw upon methods and techniques from a variety of schools that appear best suited to a client's particular problem. The difficulty is, we are sorely lacking in reliable and valid diagnostic tools and measures of adjustment for use with the mentally retarded, which must be regarded as a significant liability in terms of treatment selection. Moreover, evaluation of the retarded individual presents some unique diagnostic problems. These include differentiation of mental retardation from other learning problems, environmental deprivation, depression ("psuedoretardation"), the culturally different, dementias and organic brain syndromes, to mention a few. Certain developmental delaying syndromes, such as Cornelia de Lange or Lesch Nyhan syndromes, are associated with peculiar or self-injurious behavior patterns that may be organically, not emotionally based. To further complicate matters,

some have argued for distinguishing between the emotionally retarded and the emotionally disturbed ("dual diagnosed") mentally retarded client (Chess, 1970; Reiss, Levitan, & McNally, 1982). Clinical biases such as "diagnostic overshadowing" further confound differential diagnosis (Reiss, Levitan, & Szyszko, 1982). All of these considerations complicate matters to the extent of contributing to the "grab bag" approach to treatment.

A third reason for the emphasis on eclecticism with the retarded is that fully validated methods of counseling or psychotherapy for this population simply do not exist. At this juncture, it seems clear that treatment strategies designed for the intellectually-intact have only limited applicability to the mentally retarded, most especially those relying primarily on the attainment of "insight" for behavior change. Yet, it is not reasonable to conclude, on the other hand, that there exists a need to develope a "treatment of choice" with the retarded simply on the basis of the existence of learning handicaps, as these handicaps vary greatly in terms of origin, manifestations, and magnitude. Rather, I believe that a more realistic goal is to develope modifications in existing procedures that appear most effective in achieving change. One positive result of the uncertain value of traditional methods is that this has encouraged, indeed virtually compelled, experimentation with novel strategies. Yet, these remain largely unvalidated.

A fourth reason for the eclectic emphasis is that the psychological problems of the retarded client seldom manifest themselves in discrete

areas or situations. My own experience is that typically problems are multifaceted and stem from multiple causes. Multiple procedures are necessary to address the multidimensional nature of the individual's problems and circumstances.

Finally, a related reason is that generally speaking, treatment of the retarded individual, and specifically the generalization of treatment effects, is facilitated by treatment planning that is broad in scope. Broad spectrum treatments, of course, require that significant others respond therapeutically to the client along several different dimensions, and that treatment not be restricted to any one setting or environment.

While these and other factors have resulted in an eclectic emphasis with the retarded, it should be recognized that some have evolved from a position of weakness and uncertainty, rather than from a position whereby one can evaluate the usefulness of differing treatments objectively, determining their particular strengths or weaknesses vis a vis the retarded. Eclectic treatment of the retarded is therefore characterized by inadequate planning, idiosyncratic interventions, and the application of procedures that are of unknown benefit and quite possible valueless.

Toward Integrated Treatment Models

It may be difficult to accept my basic premise: that after more than three decades of research in counseling the retarded we know little more than when we started, and perhaps this more than anything else has contributed to the prevailing pessimism in the area. But now the task ahead can be conceptualized.

First, I believe that there must be an end to the haphazard research

that has characterized the counseling field to date, as the studies as a whole have resulted in few substantial contributions to practice, have not provided any clear directions for subsequent investigators, and therefore have confirmed little credibility for this area by any objective standards. Rather, I believe we must move beyond the chaotic mass of vague and often conflicting data to the less glamorous task of systemtatic, critical evaluation of the variables involved.

Second, I believe that the counseling field must develope a general, coherent scheme, plan, or model that will serve to guide efforts in this area, and in particular specifies the requisite characteristics of a useful counseling approach with the retarded. As a preliminary step in this direction, I would like to offer the following conceptualization.

Characteristics of a Useful Counseling Model

To begin with, a useful treatment model will be internally valid; that is, it will be consistent with what is known about the emotional-behavioral characteristics of the mentally retarded, if not based on a formal theory of personality and adjustment. Stage models of treatment may be particularly apropos with the retarded, in that emphasis is placed on a developmentally logical progression of skills acquisition. Such a model might also facilitate the assessment of "readiness" for progression to the next stage of treatment, as well as generating useful information concerning the therapeutic process. In a broader sense, the model should lend itself well to measureable treatment objectives, and will lead to an on-going generation of new, testable hypotheses.

Secondly, a useful treatment model will specifically acknowledge and

address the special learning characteristics of the retarded individual, and provide for specific treatment interventions that account for or compensate for these characteristics. The therapeutic encounter is, after all, primarily a process of communication and re-education. The identification of factors that facilitate learning in the retarded client is critical. Yet, counseling methods and programs generally make no reference to allied fields such as cognition and learning, which is all the more suprising as it is essentially these characteristics that differentiate the retarded from the non-retarded. There is an abundance of research currently available in areas such as apperception, input organization, attention, memory, information processing, cognitive style and so forth in mentally retarded persons (e.g., Ellis, 1979). These studies have great potential relevence for both optimally strucuring the counseling environment and for maximizing the acquisition of key concepts. Much of this information is already routinely applied in educational and training settings. Why not during the counseling session?

Third, a useful model will incorporate the use of techniques validated by the experimental and applied literature. To date, the bulk of the evidence suggests that for the most part these will be highly directed, action-oriented strategies such as those exemplified by social learning and cognitive approaches to intervention: modeling, social skills training, behavioral rehearsal, contracting and possibly self-management. These procedures need to be clearly described in order to permit both correct implementation of strategies and replication of findings.

Next, a useful model will include techniques that can systematically address concerns in a variety of areas: behavioral, cognitive, and affective, mirroring current trends in the field. Counseling in general, for example, has been characterized by an increasing emphasis on the role of cognitive variables (Dember, 1974), as has behavior therapy (Wilson, 1982). It is my belief that if counseling practices with the retarded are to survive, progress and remain viable they must take note of and integrate such developments. Of particular interest to the practitioner would be research in the areas of problem solving (D'Zurrila & Goldfried, 1971; Heppner, 1978), self-instructional training (Meichenbaum, 1975) and coping skills training (Barrios & Shigetomi, 1980). It seems likely that retarded individuals could benefit from such techniques, either alone or in combination with each other. In particular, they may begin to provide some answers to the persistent problems of transfer and generalization of treatment effects.

A fifth desireable characteristic of a counseling model for the retarded is that it should be cost effective. For all practical purposes, this requires that (1) there is research documenting its effectiveness, (2) treatment goals should be obtainable within reasonable timeframes, and (3) the techniques derived should be simple enough to be carried out by those who may not have the usual mental health background and credentials, but who can nevertheless carry out the requisite activities with training and appropriate supervision. While individual counseling may be indicated in some cases, the economic and process advantages of group treat-

ment make this a preferred medium whenever possible (Spragg, Note 2).

Finally, in order for counseling to be an attractive alternative to operant or other intervention methods, it must carry with it a competitive advantage, i.e., some unique or special advantages not offered by these other strategies. These might include demonstrated efficacy in generalization of treatment effects, maintenance of treatment effects, or broad behavior change capabilities. Success in counseling the retarded may be of clinical interest yet be of little practical value if other approaches can achieve the same results more efficiently.

Summary and Conclusions

T would like to close this morning that emphasizing that whether there will continue to be a place for counseling with the mentally retarded depends on at least four things: (1) how effectively we can marshall the evidence to document the need for counseling and communicate this to those who are directly involved; (2) how critical and objective we are in examining the data base and relevent research; (3) how flexible we are in adapting and integrating relevent research from allied fields and perspectives; and (4), how innovative and creative we are in the development of new treatment strategies. This paper has been an attempt to briefly address these and other issues.

Does counseling work with the retarded? There appear to be things that make a difference as a result of the special activities and attention provided, yes. However, this conclusion must be tempered by noting the lack of a theoretical model for research and practice, the existence of

methodologically inadequate and conflicting literature, and by noting that the effectiveness of counseling has been challenged with the intellectually intact, let alone the mentally retarded. Certain changes may be called for in terms of how we are willing to view the counseling process. It appears as though counseling models with the retarded must de-emphasize traditional, dynamic constructs (e.g., insightful thinking) and focus more on relevent learning and psychoeducational processes, as well as functional relationships existing among the behavioral, cognitive, and affective domains. There does not exist, nor is there ever likely to exist, a single mode of treatment, a school of therapy, or a family of techniques that can be considered the "treatment of choice" with the retarded. This is not a homogeneous population, and it is plain that individual assessment of the retarded individual is critical in formulating a treatment plan. Equally important is our ability to objectively assess outcome, as I personally believe that therapists should not be able to proclaim the benefits of counseling without being accountible for such statements.

So a more meaningful question is: are we at a point where we can, in a selective and discriminating manner, confidently employ counseling techniques with the mentally retarded, with reasonable expectations of measureable and meaningful outcomes? The answer is clearly no. But with a coordinated and systematic attack on the problem, this is a goal which we can realistically hope to achieve.

Reference Notes

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